IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

LOIS E. MARX, et al.,	:	
	:	
Plaintiffs,	:	CIVIL ACTION
	:	
v.	:	
	:	NO. 99-CV-4484
	:	
MERIDIAN BANCORP, INC. LONG TERM DISABILITY PLAN, et al.,	:	
	:	
	:	
Defendants.	:	

M E M O R A N D U M

BUCKWALTER, J. June 20, 2001

Presently before this Court is a Motion for Summary Judgment on behalf of defendants, Meridian Bancorp, Inc. Long Term Disability Plan et al. ("Defendants").

Plaintiff Lois E. Marx ("Plaintiff") brought this suit for long term disability benefits ("LTD") under 29 U.S.C. §§ 1001-1461, the Employee Retirement Income Security Act of 1974 ("ERISA") and alleged improper denial of benefits as well as breach of fiduciary duty. For the reasons set forth below, Defendants' Motion for Summary Judgment will be granted in its entirety.

I. BACKGROUND

Beginning in 1991, Plaintiff worked as a secretary for Meridian Bancorp, Inc. ("Meridian"). Then, in January 1995, Plaintiff requested a leave of absence on account of back pain which she claimed affected her ability to sit or stand for extensive periods of time. With the support of her treating physician, Plaintiff filed a claim for LTD with Defendants under the Meridian Bancorp, Inc. Long Term Disability Plan[1] (the "Plan") alleging an inability to work on account of this pain and the depression it caused her.

To establish a claim for LTD under the Plan, a claimant must show that she is unable to perform the duties of her job. If a claimant can establish disability under this standard, she may receive benefits during a two year "Waiting Period." After the two years, a claimant's eligibility is assessed under more stringent standard, one which requires Plaintiff to demonstrate that she is unable "to perform *any* occupation for which she is qualified or may reasonably become qualified by training, education or experience." § 1.31 of the Plan. (emphasis added)

Plaintiff succeeded in her claim to receive LTD under the initial standard and received benefits for the two year Waiting Period. During that time, Plaintiff consulted other doctors, underwent surgery for her back and took steps to establish a claim for permanent disability benefits. For instance, she submitted medical records to the Plan Administrator, received an independent medical examination conducted by Dr. O'Brien and filed for Social Security Disability Income ("SSDI"), all in accordance with the Plan's requirements.

At the end of the Waiting Period, Defendants reevaluated Plaintiff's eligibility under the more stringent standard of review and denied Plaintiff's benefits. Plaintiff appealed

1. The Plan is self-funded and it contracts with MetLife to handle adjudication of claims.

this determination and argued that SSA's 1996 finding of total disability should have resulted automatically in the same decision by Defendants. Plaintiff also criticized the behavior of the independent medical examiner and hence questioned the credibility of his findings. Despite these arguments, Defendants upheld their decision on appeal.

In 1998, Plaintiff, represented by counsel, sought a third review of her claim. Plaintiff again argued that the SSA's findings should have been conclusive. The Claim Administrators, Metropolitan Life Insurance Company ("MetLife"), informed Plaintiff that she could submit additional medical evidence and Plaintiff followed this suggestion. However, MetLife ultimately informed Plaintiff that it would not re-open her case. Plaintiff subsequently filed this claim with this Court.

II. LEGAL STANDARD

A motion for summary judgment shall be granted where all of the evidence demonstrates "that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). A genuine issue of material fact exists when "a reasonable jury could return a verdict for the nonmoving party." Anderson v. Liberty Lobby Inc., 477 U.S. 242, 248 (1986). "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment." Id.

If the moving party establishes the absence of the genuine issue of material fact, the burden shifts to the nonmoving party to "do more than simply show that there is some

metaphysical doubt as to the material facts." Matsushita Elec. Indus. Co. v. Zenith Radio Corp., 475 U.S. 574, 586 (1986).

When considering a motion for summary judgment, a court must view all inferences in a light most favorable to the nonmoving party. See United States v. Diebold, 369 U.S. 654, 655 (1962). The nonmoving party, however, cannot "rely merely upon bare assertions, conclusory allegations or suspicions" to support its claim. Fireman's Ins. Co. v. DeFresne, 676 F.2d 965, 969 (3d Cir. 1982). To the contrary, a mere scintilla of evidence in support of the non-moving party's position will not suffice; there must be evidence on which a jury could reasonably find for the nonmovant. Liberty Lobby, 477 U.S. at 252. Therefore, it is plain that "Rule 56(c)" mandates the entry of summary judgment, after adequate time for discovery and upon motion, against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). In such a situation, "[t]he moving party is 'entitled to a judgment as a matter of law' because the non-moving party has failed to make a sufficient showing on an essential element of her case with respect to which she has the burden of proof." Id. at 323 (quoting Fed. R. Civ. P. 56(c)).

III. DISCUSSION

A. Appropriate Standard for Analyzing Plaintiff's Claim

In reviewing a claim for denial of disability benefits under ERISA, the Supreme Court held in Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989) that:

> a denial of benefits challenged under § 1132(a)(1)(B) [which governs the validity of a claim for benefits under an ERISA plan] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

The Third Circuit subsequently held that where de novo review is inappropriate, an arbitrary and capricious standard should be applied in evaluating a claim against a plan administrator for denial of benefits. See, e.g., Stoetzner v. United States Steel Corp., 897 F.2d 115, 119 (3d Cir. 1990). Therefore, a threshold question for the Court is which standard to apply.

To determine the standard of review, the Court begins with the language of the plan and evaluates whether the benefit plan gives the administrator or the fiduciary discretionary authority to determine eligibility or interpret the terms of the plan. See Firestone, 489 U.S. at 115; see also Stoetzner, 897 F.2d at 119. This grant of discretion can be express or implied. See Luby v. Teamsters Health Welfare and Pen. Trust Funds, 944 F.2d 1176, 1180 (3d Cir. 1991). If there is no direct language to indicate a grant of discretion, language suggesting that the Plan administrator[2] will make the final decision as to eligibility may be enough for the Court to find the Plan administrator has authority. See, e.g., Mitchell v. Eastman Kodak Co., 113 F.3d 433,

2. In the development of this approach, the courts have borrowed from principles of trust law. See Moench v. Robertson, 62 F.3d 553, 566 (3d Cir. 1995). The integration of these concepts into ERISA law, however, does not limit the analysis only to cases where entities are labeled as fiduciaries. In fact, the Supreme Court stated that *de novo* review is proper except where an administrator *or* a fiduciary receives a grant of discretion. See Firestone, 489 U.S. at 115.

438-9 (3d Cir. 1997) (describing language and provisions where arbitrary and capricious standard is appropriate).

The Plan before this court does not contain a direct grant of authority to MetLife. However, the Plan does include the type of language which other courts in this circuit have held to grant discretion to the Plan Administrator and the Claims Administrator. See, e.g., id. at 438 n.5 Here, the necessary language for this grant of discretion is sprinkled throughout the Plan. Specific examples can be found in Article 6.04 under "Claim Procedure" which establishes the Plan Administrator as the entity that processes the claims. The same article subsection (g) provides that the Plan Administrator may request an independent medical examination of the claimant. Additionally, Article 6.04 (j) delegates the review of a denial of benefits to the Claims Administrator, whose decision as to eligibility is final. These provisions taken in conjunction with § 6.09, the "Administration" section of the Plan, and the of tasks set forth in Article I, indicate a grant of discretion to the Plan and Claims Administrators, making the arbitrary and capricious standard appropriate.

Plaintiff takes issue with this understanding of the Plan's language and alleges that MetLife did not receive a grant of discretionary authority and therefore a *de novo* standard is required. Plaintiff contends that although Meridian abdicated its own authority to MetLife, this transfer does not confer the discretionary authority on MetLife. Plaintiff supports its argument by citing a Article I of the Administrative Services Agreement ("Agreement") between the contractholder [Plaintiff], the Plan Administrator [Administrative Committee for Employee Benefits of Meridian Bancorp, Inc.] and Metropolitan Life Insurance Company which states that "Metropolitan acts solely as an agent of Meridian Bancorp Inc. and/or The Administrative

Committee and not as a fiduciary as that term is defined under the Employee Retirement Income Security Act of 1974." See Def. Exh. 47. Plaintiff again argues that these statements mean MetLife has no authority to determine eligibility and therefore its decision should be disregarded.

However, as indicated *supra*, Meridian hired MetLife, as provided for in Article I of the Plan, and delegated to it certain responsibilities including the job of Claims Administrator. This arrangement is illustrated by the introductory paragraph to the Agreement stating, "Administrative Committee has delegated authority to act on behalf of the plan administrator." Moreover, Section C.4. of the Agreement explains that MetLife will "[e]valuate claims submitted, consistent with the terms and provisions of the Plan and with the interpretative rules and regulations issued by the appropriate Plan Fiduciary." This provision also allows for MetLife to decide whether a review of an applicant's claims shall require additional investigation into the claims. Taken together with the structure of MetLife's responsibilities, these provisions reveal that MetLife is the adjudicator of disability claims for the Plan and suggest an almost unavoidable grant of discretionary authority by Meridian to MetLife. Therefore, an arbitrary and capricious standard of review of Plaintiff's claim for benefits is appropriate.

Having determined that MetLife is an administrator of disability benefits, the Court can discount another of Plaintiff's arguments for de novo review. Plaintiff asserts that as MetLife is not a fiduciary under ERISA,[3] de novo review cannot be applied. However, as explained *supra*, this argument relies too heavily on the role of fiduciary law in this analysis. Although some fiduciary law has been used in the ERISA analysis, the word fiduciary does not

3. Plaintiff identifies the introductory statement in the Agreement which states MetLife is not a fiduciary under ERISA. See Agreement *supra*.

appear in this portion of the statute. See 29 U.S.C. § 1132(a)(1)(B). Moreover, the Supreme Court in Firestone stated that the de novo review is applicable except where discretion was granted to either an administrator *or* a fiduciary. So, rather than focusing on the technical designation of MetLife as a non-fiduciary, the Court examines the actual implementation of the benefits plan and the language that guides this operation. Under this analysis, the Court deems that MetLife is an administrator as described by the Supreme Court in Firestone, and as such, it has received a grant of discretionary authority. Hence, the Court applies the arbitrary and capricious standard to Meridian's denial of Plaintiff's benefits.

B. Application of Arbitrary and Capricious Standard to Count I

Where the arbitrary and capricious standard is applied, the Court is given a limited scope of review and "the district court may overturn a decision of the Plan administrator only if it is 'without reason, unsupported by the evidence or erroneous as a matter of law.'" Abnathya v. Hoffman LaRoche, Inc., 2 F.3d 40, 45 (3d Cir. 1993) (quoting Adamo v. Anchor Hocking Corp., 720 F.Supp. 491, 500 (W.D. Pa. 1989)). The Court understands Plaintiff to asserts three grounds for denying summary judgment even under this narrow standard. First, Plaintiff claims that the file reviewed by MetLife was incomplete. Second, Plaintiff alleges that Defendants gave no weight to the SSA's decision that Plaintiff was disabled. Third, Plaintiff asserts that Defendants' decision rested too heavily on the observations of Dr. O'Brien, the independent medical examiner, and that Dr. O'Brien did not reach any medical conclusions but instead attacked Plaintiff in an *"ad hominem"* manner.

As to the first issue, Plaintiff alleges that the materials reviewed by MetLife in evaluating her claim were incomplete. Plaintiff professes in an affidavit that she had provided

MetLife with documents that were not contained in MetLife's file. However, Defendants submit an affidavit from a MetLife employee confirming that the documents contained in the file Plaintiff received from MetLife were the complete contents of Plaintiff's file. Plaintiff states in her affidavit that she mailed the missing documents to Defendants in June 1997 and again in February 1998. However, several letters included among those documents were dated May and June of 1998. This temporal discrepancy leads the Court to question the integrity of Plaintiff's affidavit and in the absence of any evidence other than Plaintiff's assertions that she submitted these materials, the Court does not find that this issue is sufficient to preclude a grant of summary judgment in favor of Defendants.

The second reason Plaintiff produces for denial of summary judgment is that Defendant did not rely heavily on the decision of the SSA in making its own determination as to Plaintiff's disability. To support this contention, Plaintiff highlights the provisions of the plan that require a claimant to apply for Social Security Disability Income ("SSDI") in order to retain LTD. Plaintiff also mentions the absence of any reference to the Social Security Administration's evaluation when Defendants rendered their decision.

While Plaintiff is correct that a finding of disability by the SSA is a prerequisite to obtaining disability under the Plan, the language of the Plan does not require that a finding of disability by the SSA mandates a parallel determination under the Plan. Instead, a SSA finding is one factor among many that may be considered when granting disability benefits. Although Defendants here did not present their reasons for disagreeing with the SSA's decision, they similarly did not discuss in detail their analysis of other documents or types of evidence; therefore, their decision not to mention the SSA's findings does not mean that the evidence was

not considered. Furthermore, as Defendants' decision is reasonably supported by the record, the Court believes that Defendants' treatment of the SSA's findings does not render their decision invalid.

Finally, as to the adequacy of Dr. O'Brien's evaluation, Plaintiff contends that Dr. O'Brien's conclusions were unfounded because he checked boxes on a standard questionnaire that indicated he was unable to make some determinations regarding Plaintiff's abilities. However, in focusing on these checkmarks, Plaintiff ignores the detailed narrative that Dr. O'Brien provided in which he placed his overall observations of Plaintiff into a context. Included in this four-page, single-spaced analysis, Dr. O'Brien mentions that Plaintiff was uncooperative and recalcitrant and he explains his observations. In light of Plaintiff's behavior, the fact that Dr. O'Brien's conclusions are supported by other evidence in the record and the fact that the Court places more significance on Dr. O'Brien's discussion than on the checkmarks on a form, the Court finds that MetLife's reliance on Dr. O'Brien's analysis does not render MetLife's decision arbitrary and capricious.

C. Breach of Fiduciary Duty

Plaintiff alleges breach of fiduciary duty under ERISA § 502(a), 29 U.S.C. § 1132 (a) and claims that Defendant's failure to follow certain procedures resulted in the denial of her disability benefits. Specifically, Plaintiff contends that she was arbitrarily denied an adequate review of her claim and therefore should be entitled to an additional appeal. However, Plaintiff fails to provide any evidence that in the absence of these alleged procedural deficiencies, MetLife would have decided her claim for benefits differently. For instance, Plaintiff contends that her appeal of the Plan's denial of LTD violated the Plan procedures because the Plan Administrator

allegedly did not supervise MetLife's review of her claim. The Court finds this grievance to be unsupported. The Plan is self-funded so MetLife has no self-interest in denying Plaintiff benefits. Additionally, Plaintiff fails to provide evidence that the alleged failure to comply with Plan procedures caused her denial of benefits. Without demonstrating causation, Plaintiff's claim for breach of fiduciary duty must fail. See Mose v. United States Health Care Sys., No. 95-6553, 1996 U.S. Dist. LEXIS 9913, at *5 (stating that denial of benefits alone is not grounds for a breach of fiduciary duty). Accordingly, Plaintiff's claim does not survive the motion for summary judgment.

IV. CONCLUSION

For the foregoing reasons, Defendants' Motion for Summary Judgment is GRANTED in its entirety as to all claims and all defendants.

An appropriate order follows.

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	:	
Defendants.	:	

O R D E R

AND NOW, this 20th day of June, 2001, upon consideration of Defendants' Motion for Summary Judgment (Docket No. 17), Plaintiff's response thereto (Docket No. 19), Defendants' reply (Docket No. 21) and Plaintiff's sur-reply (Docket No. 24), it is hereby ORDERED that Defendant's motion is GRANTED in its entirety and Plaintiff's complaint is dismissed.

This case is CLOSED.

BY THE COURT:

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RONALD L. BUCKWALTER, J.